STATE OF ALABAMA
DEPARTMENT OF FINANCE
DIVISION OF RISK MANAGEMENT
STATE EMPLOYEE INJURY COMPENSATION TRUST FUND (SEICTF)

MILEAGE REQUEST

Claimant Name: _____ Employer: _____

Address: _____ Date of Injury: _____

_____

Social Security #: _____ Claim #: _____

Name & Address of Provider	Date of Treatment	Mileage (Round Trip)

I certify the above information is accurate.

Claimant Signature: _____

Date: _____

TO BE COMPLETED BY SEICTF:

ACCOUNT CODES: _____ _____ _____

SEICTF Form 11 05/04